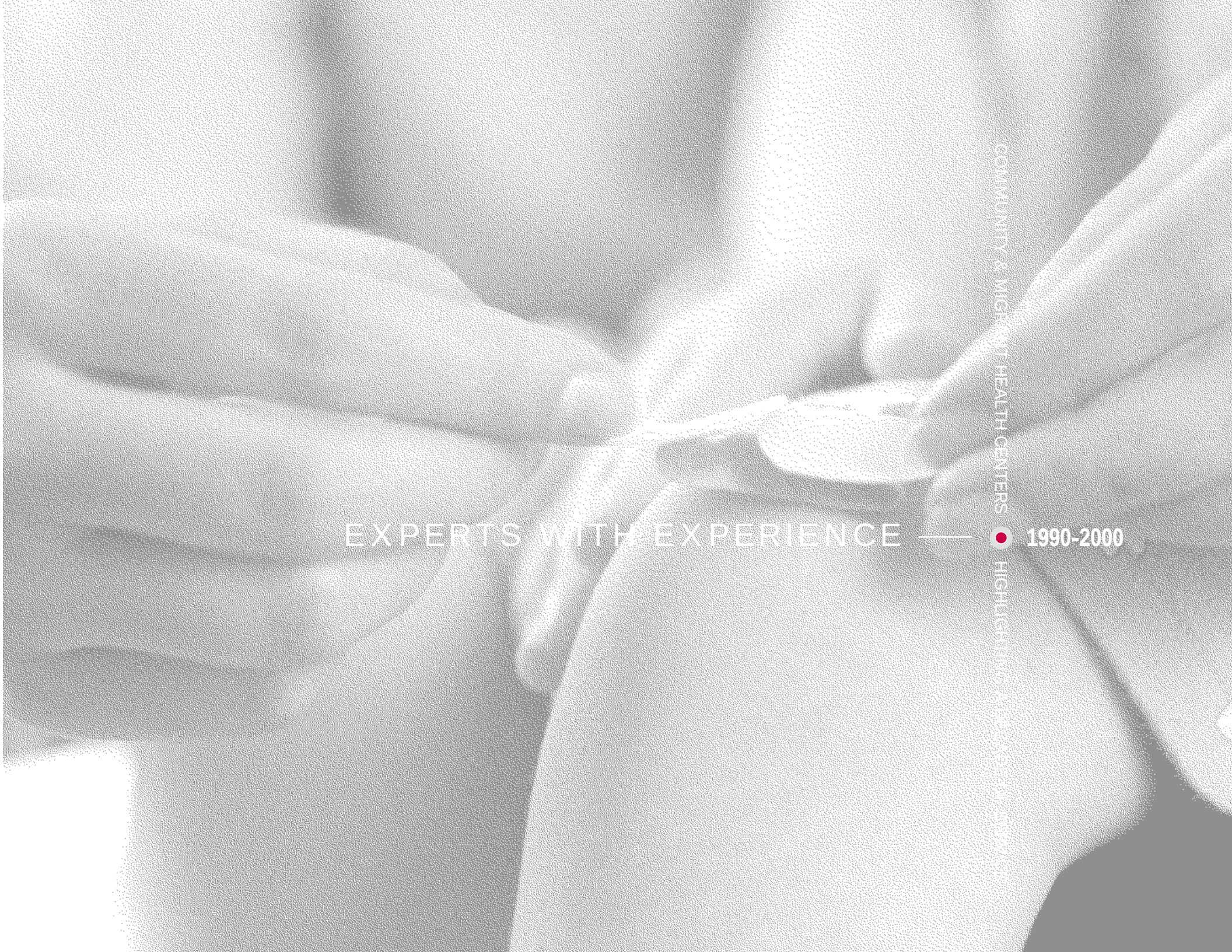

EXPERTS WITH EXPERIENCE
1990-2000
COMMUNITY MICHIGAN HEALTH CENTERS

A MESSAGE FROM THE DIRECTOR OF DCMH

The health center movement has come a long way during the last thirty-five years. This movement began with the creation of the migrant health center program followed by the precarious neighborhood health center demonstration projects initiated in 1965 as part of President Johnson's War on Poverty. Today, approximately 700 health centers with nearly 3,000 clinics and a network of 6,500 primary care clinicians provide services to over 9 million people. Community-based migrant and community health centers have become a mainstay of our Nation's health care delivery system for vulnerable and underserved populations. The health center program continually strives to meet the changing realities and demands for care to uninsured and other vulnerable people across the Nation.

In the last decade, the focus of this report, the number of people served increased by almost 100 percent, the number of access points doubled, the number of primary care providers nearly doubled, and Congressional appropriations increased by 100 percent. The current generation of health centers is operating in an environment characterized by market competition and managed care for publicly and privately insured patients, and by increased demands on safety-net providers to serve a growing number of uninsured and underinsured people.

As you will read in the pages that follow, the decade of the 1990s challenged the financial viability of health centers. But, you will also see how health centers have responded to those challenges while remaining true to their mission – that of addressing the multi-faceted needs of the unique communities they serve. Health centers contribute to a healthy workforce and are significant employers and purchasers who attract over three dollars for every one dollar of federal investment. Health centers are economic engines – catalysts for overall community development. They are woven into the fabric of the communities, the people, and the lives that they touch.

The Division of Community and Migrant Health (DCMH) is proud to have assisted health centers in dealing with the challenges of the last decade, and I look forward to the opportunities and challenges of the next. Those health centers that began as an experiment thirty-five years ago along with their successors have truly become experts with experience. They will continue to lead the country in the provision of quality primary health care for America's underserved and vulnerable people.

Richard C. Bohrer
Director
Division of Community and Migrant Health
Bureau of Primary Health Care


EXPERTS WITH EXPERIENCE

OVERVIEW OF THE HEALTH CENTER PROGRAM

In 1964, the Office of Economic Opportunity (OEO) was formed as a part of the Economic Opportunity Act (EOA). As a component of President Johnson's Great Society, the OEO was charged with the arduous task of eradicating poverty by improving the social and economic situation of the Nation.

The OEO soon realized that by addressing untreated health problems of the poor, the economic burden of this segment of society could be eased. In 1965, eight neighborhood health centers (NHCs) were funded. These centers were considered demonstration projects for the creation of comprehensive health services programs oriented towards the needs of the vulnerable and underserved.

During the early years of the program, NHCs were successful in achieving many of the initial programmatic goals. For example, centers made great strides in eliminating barriers to health care for the poor and underserved, ensuring continuity of care, promoting the use of preventive services, increasing community participation and control, and promoting the use of new categories of health care providers such as nurse practitioners and physician assistants. Health centers also served as job training programs for many economically disadvantaged communities. The principal distinctions between the NHC program and other programs that sought to improve access to care were its range of medical and non-medical services and its mission to serve all comers regardless of ability to pay.

The NHC program has evolved today into the community/migrant health center (C/MHC) program administered by the Division of Community and Migrant Health (DCMH) within the Health Resources and Services Administration's (HRSA) Bureau of Primary Health Care (BPHC). Despite major growth and widely varying challenges throughout the program's history, the mission has remained the same – the provision of high-quality primary and preventive health care services to people in rural and urban medically underserved areas. In recent years, the BPHC has embraced a more far-reaching goal. That is to ensure access to quality primary health care for all underserved and vulnerable people, and to reduce to zero any disparities in health status among racial/ethnic groups. Community and migrant health centers serve as the foundation for accomplishing this goal.

Health Center Mission

Health centers provide family-oriented primary and preventive health care services for people living in rural and urban medically underserved communities regardless of their ability to pay.

Health centers overcome economic, geographic, or cultural barriers to primary health care, and they tailor services to the needs of the community.

1990 – 2000 CHANGE BROUGHT CHALLENGE

Changes in the health care environment over the last decade have posed new challenges to health centers and threatened their viability.

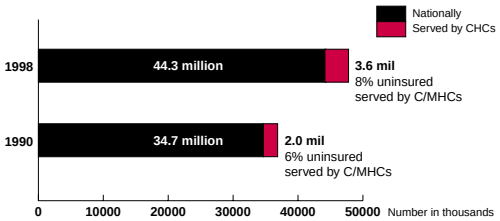
Increasing Uninsured

While the decade of the 1990s brought one of the greatest economic surges this country has known, the benefits of this triumph were not realized across all segments of the population. For example, the number of uninsured Americans continued to rise at a rate of almost one million people per year – from 34.7 million (13.9 percent), to 44.3 million (16.6 percent) in 1998, over 11 million of whom were children.[1] At the same time, the numbers of uninsured people seen at health centers increased at an even greater rate – from 2 million in 1990 to 3.6 million in 1999, an increase of over 80 percent![2]

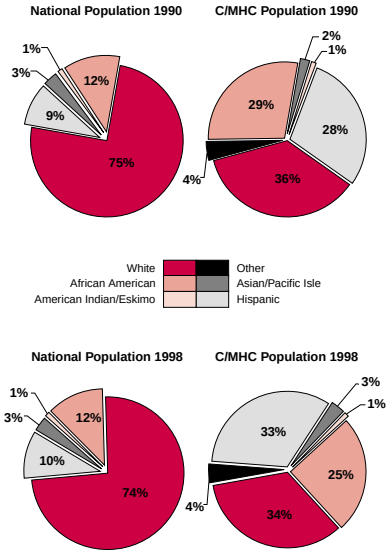
Increasing Immigration

Adding to this situation was an increase in immigration. At the beginning of the decade, 7.9 percent of the population was foreign born. By the end of the decade, immigrants made up almost ten percent of the national population.[3] Of these immigrants, one-half are from Latin American, the majority of whom were born in Mexico. One-fourth are from Asia. Studies have shown that about one third of foreign-born residents are in the ranks of the uninsured, largely because they are ineligible for public insurance programs and often work in jobs where insurance coverage is not provided.[4]

Uninsured Americans



C/MHCs treated 80% more uninsured in 1998 than they did in 1990

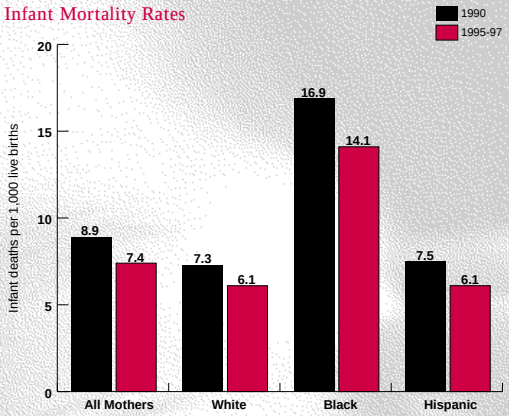


While these immigration patterns resulted in only a one percent shift from White to Hispanic in the national population, the changes in health center patients showed a more dramatic change. The percent of White patients fell from 36 percent to 34 percent and the number of African American patients dropped from 29 percent to 25 percent while Hispanic patients increased from 28 percent to 33 percent.[5]

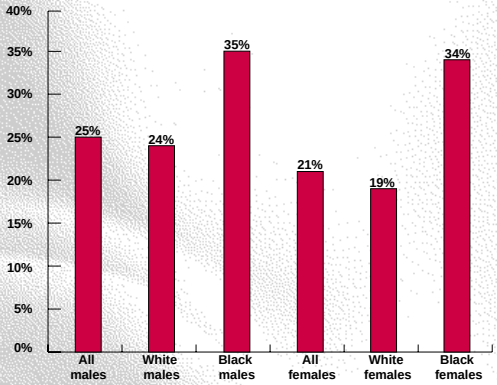
Increasing Disparities in Health Status

In addition to having a greater likelihood of being uninsured, racial and ethnic minority residents suffer disproportionately from higher rates of disease. For example, although there have been overall improvements in health status indicators, infant mortality rates remain much higher for African Americans than for white Americans. African Americans suffer from hypertension at rates well above the rate for white Americans, and immunizations are significantly higher for white children than for other racial and ethnic minority children.[6]

Infant Mortality Rates

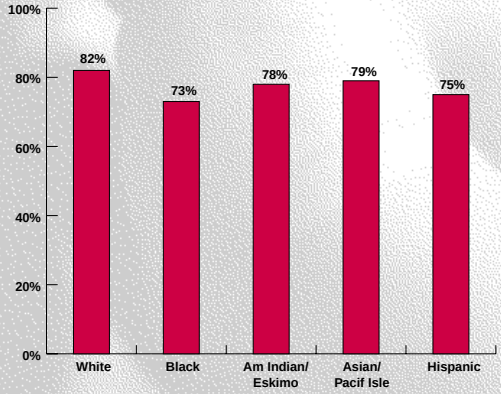


Adult Hypertension



In persons 20 years of age and over for years 1988-94

Complete Vaccinations



Vaccinations among children 19-35 months of age 1994-98

Changing Financing

Late in the 1980s, the enactment of Federally Qualified Health Center's (FQHCs) legislation had a significant impact on health centers. This legislation was intended to enhance access to outpatient primary and preventive health care services for Medicaid and Medicare beneficiaries by covering a greater portion of costs incurred in serving these patients. With FQHC designation, health centers were eligible for reimbursement based on the reasonable costs of providing the service. Prior to FQHC designation, reimbursement rates for services provided were frequently inadequate to cover the actual costs of the services provided to Medicare and Medicaid patients. This resulted in C/MHC grant dollars being diverted from services for the uninsured to subsidizing Medicaid and Medicare.

In the ten years since the enactment of cost-based reimbursement, health centers have been able to increase their capacity for serving the uninsured by 1.6 million people – more than 80 percent. However, in 1997, the Balanced Budget Act provided for the phase out of FQHC payment. The Balanced Budget Refinement Act of 1999 delayed implementation of the phase-out and calls for a study to determine how C/MHCs should be paid in the future.

There have also been recent reports that enrollment in Medicaid is declining, which may result in further growth of the uninsured population served by health centers. Although passage of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, which is expected to reduce welfare rolls by 30 to 40 percent by 2001, was not intended to change Medicaid eligibility, in fact, many people removed from welfare rolls have also lost their Medicaid benefits.[7] Traditional sources of funds are being threatened by this erosion in the numbers of publicly funded patients accompanied by an increase in the uninsured.

Managed Care

One of the major changes and challenges of the decade of the 1990s has been managed care. In an effort to reduce costs, many states moved to Medicaid managed care. Although most health centers were able to contract with managed care plans, the discounted payments offered sometimes led to losses in Medicaid revenues. This reduction in revenue was compounded by the fact that some centers lost market share as other providers began to compete for patients. In addition, when Medicaid patients failed to select a primary care provider, some were automatically assigned to providers other than health centers.[8]

These and other national developments have combined to place increasing stress on community and migrant health centers with the result that the ability of many of the most vulnerable Americans to gain access to essential health care services has been threatened throughout the decade.

ADDRESSING THE CHALLENGE

Community and migrant health centers respond as "Experts with Experience" in providing quality health care services to underserved and vulnerable people.

Working to Increase Service

During the last ten years, health centers have demonstrated their value in a dynamic health care marketplace by playing an increasingly essential role in the nation's safety net. Health centers provide preventive and primary care to the following population across the Nation:

- 8 percent of the 44 million uninsured
- 9 percent of its 32 million Medicaid recipients
- 19 percent of the 43 million underserved people living in federal designated underserved areas lacking access to primary care providers.[9]

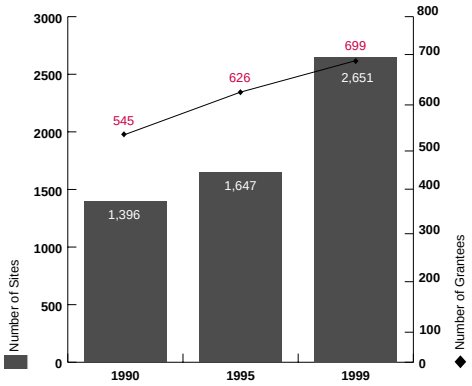
In the last decade, the number of C/MHCs has increased from 545 to nearly 700, and the number of service delivery sites increased from 1,400 to nearly 3,000.

While there has been a 28 percent increase in the number of C/MHC grantees, there has been nearly a doubling in the number of people served, from approximately 5.1 million in 1990 to nearly 9 million in 1999 based on preliminary data.[10] A valuable partner in providing health services has been the National Health Service Corps, whose efforts have enhanced the workforce of C/MHCs nationwide.

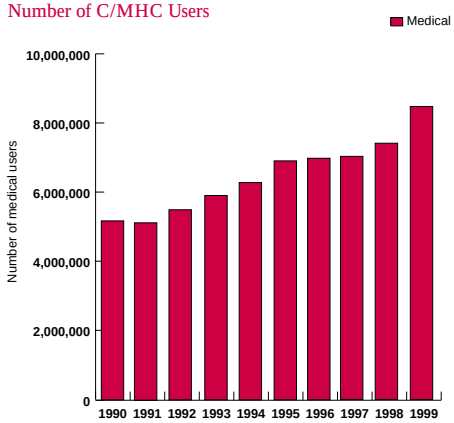
Most dramatic has been the health centers response to the growth in the uninsured. Nationally, the uninsured growth rate peaked at 28 percent in 1998, then declined in 1999 to 23 percent. The rate for health centers, however, continues to rise despite the apparent reversal of a previous 12-year national trend, increasing from 74 percent to 82 percent from 1998 to 1999.

Although health centers have been challenged to survive in the rapidly changing landscape of the health care industry, they have continually demonstrated that they are an efficient and effective choice for providing health care services to the medically underserved of this country. Centers have shown their ability to understand and respond to the most pressing health care needs of the community and to positively impact the health status of the communities they serve, especially those populations that other providers choose not to see.

Growth of C/MHCs

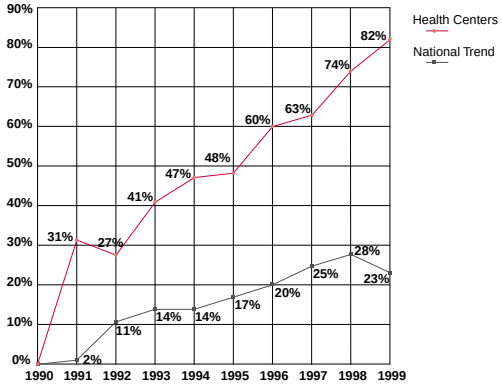


Number of C/MHC Users



From 1990 to 1999, the number of C/MHC medical users increased by 61%

Uninsured Users in Health Centers' Rate of Growth is more that 2-1/2 times the National Rate



Note: Data for 1990-1995 reflects C/MHCs only; 1996-1999 reflects C/MHCs, as well as public housing, homeless health centers, etc.
Source: BCRR/UDS and Census Bureau data for 1990-1999

Working to Reduce Health Disparities

Health centers have long been laboratories for reducing health disparities including such areas as immunization rates, infant mortality/low birthweight, diabetes, and cancer screening. Recent studies have shown that both infant mortality and low birthweight rates among health center patients are lower than the rates for the general population. Overall, the low birthweight rates for C/MHC patients are lower, but the disparities continue to exist, illustrating the need to continue the fight to reduce this condition.

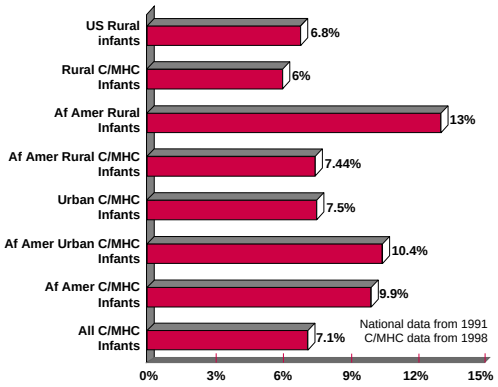
A C/MHC user visit survey also revealed the effectiveness of health centers in conducting routine cancer screenings, showing that female health center patients are more likely to obtain mammography, Pap smear tests, and clinical breast exams than are patients who use other facilities.[11] What is more impressive is that these findings apply to African American, Hispanic, and white C/MHC patients when compared to other low income patients in the general population.

Since 1962, migrant health centers have been providing a broad array of medical and support services to migrant and seasonal farmworkers and their families in a culturally sensitive manner. Migrant and seasonal farmworkers have some of this Nation's most severe health and social problems and are at greater risk than the general population due to a number of factors such as poverty, malnutrition, infectious diseases, exposure to pesticides, and poor housing. Services targeted to this population through the migrant health program include primary care, preventive health care, transportation, outreach, dental, pharmaceutical, and environmental health.

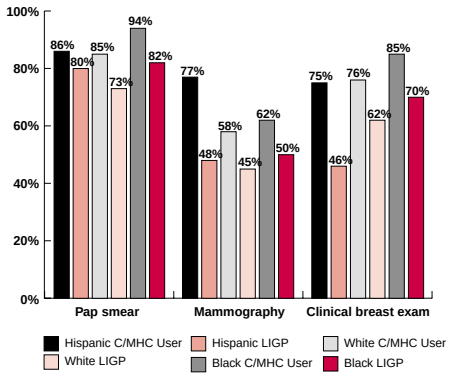
Currently, there are 121 migrant health programs nationwide providing primary health care services at more than 400 sites across 40 states and Puerto Rico. Approximately 50 percent of migrant and seasonal farmworkers served in migrant health centers are Hispanic, 35 percent are African American, and the remaining 15 percent include Asian, white or other.

Especially challenged are health centers at the area of the Nation along the Mexico border. If made the 51st State, the 11 million people residing in the four-state border region (California, Arizona, New Mexico and Texas) would rank last in access to health care (30 percent uninsured), second in death rates due to hepatitis, and third in deaths related to diabetes. Tuberculosis, which is quickly becoming drug resistant, is six times the national rate; measles and mumps are twice the national rate. In addition, HIV/AIDS is spreading rapidly. Treatment for communicable diseases such as TB and HIV as well as chronic conditions are complicated by a number of factors including the extremely high volume of cross border traffic, back and forth migration, and differences in U.S. and Mexican health care protocols.

Low Birthweight Among Rural, Urban, and C/MHC Infants



Cancer Screening: 1994 C/MHC Users and 1992 Low-Income General Population (LIGP)



To address these growing challenges in the four-state region, the U.S.-Mexico Border Health Program was created August 1996. This program has as its charge improved intra-agency planning, coordination, and program implementation, and the development of partnerships with local, State, Federal and private partners.

In collaboration with the Institute for Health Care Improvement, the BPHC initiated a program to improve access to quality diabetes care. In general, the goals of this initiative are to: (1) decrease or delay the complications of diabetes, (2) decrease the economic burden for patients and the community, and (3) generate and document improved health outcomes for underserved populations. Currently, there are plans to establish and implement collaboratives around other chronic diseases such as asthma.

Working to Increase Revenue Sources

Since their beginning 35 years ago, health centers have been forced to utilize a patchwork of public and private resources to increase their capacity to serve the underserved. Over the past 10 years the challenges to financial viability have increased, yet health centers have continued to bring together a variety of revenues, enabling them to survive in this environment. Medicaid revenues increased from 20 percent to 32 percent, while dependency on section 330 dollars decreased from 40 percent to 27 percent during this time, as health centers became more active in seeking other sources of revenue. In fact, non-grant sources of revenue increased by an astounding 500 percent, from approximately $450 million in 1990 to $2.24 billion in 1999.[12]

The existence of FQHC required cost-based reimbursement has been a major factor in the increase and has helped to cushion the downward pressure in Medicaid rates, making this reduction of federal grant dependency possible. However, the shift to greater dependency on FQHC reimbursement has also left centers vulnerable to Medicaid policies that vary widely from state to state.

Since the early 1990s, a new category of safety net providers that increased access to care has been recognized – health centers that meet with requirements of the section 330 grant program but do not receive grant dollars. This category of health centers has been labeled FQHC Look-Alikes.

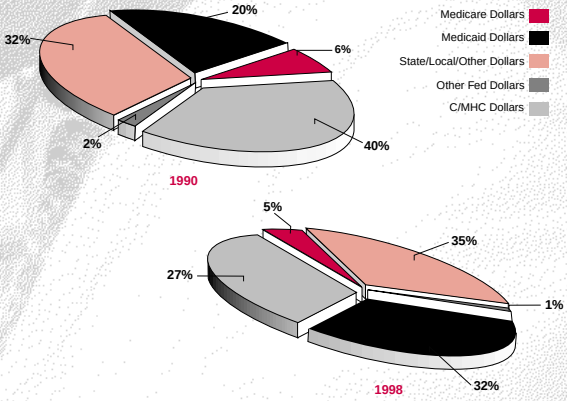
FQHC Look-Alikes receive no section 330 Federal funding but are eligible for cost-based reimbursement under Medicaid and Medicare and participate in the 340(b) Federal Drug Pricing program. FQHC Look-Alikes must meet section 330 requirements for need and community impact, health services, management and finance, and governance. FQHC Look-Alikes are part of the strategy to strengthen the safety net for populations at risk. The program has grown from the initial 28 designations in 1991 to the current 111 designated health centers, with 182 sites, providing primary care services to over 1,120,000 users. Approximately 40 FQHC Look-Alikes have competed for and been approved for section 330 funding during this time.

Working with Managed Care

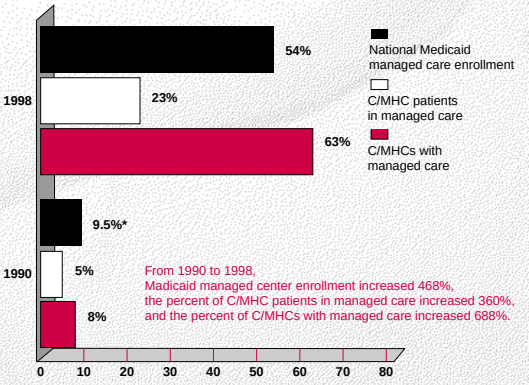
Over the past decade, managed care, particularly Medicaid managed care, has had major implications for health centers. While most centers have adapted well, the downward pressures on revenues resulting from discounted payments and plan enrollment practices that may shift patients to other providers continue to provide cause for concern. According to HCFA figures, national enrollment of Medicaid eligibles in managed care has increased from 9.5 percent to approximately 55 percent within the last ten years.

In C/MHCs, there has been a seven-fold increase in managed care enrollees, from 230,000 to 1.6 million. Health centers have formed 21 managed care plans across 15 states enrolling almost 1.1 million members, primarily Medicaid. During the past decade, managed care has forced health centers to examine new and innovative arrangements to further expand the provision of services and programs to underserved populations, as well as to survive in the changing health care environment. Health centers have embarked upon various practice management arrangements including horizontal and vertical collaborative agreements with other providers to remain competitive in the era of managed

Souces of Funding



Managed Care Growth



From 1990 to 1998,
Madicaid managed center enrollment increased 468%,
the percent of C/MHC patients in managed care increased 360%,
and the percent of C/MHCs with managed care increased 688%.

*1991 data is shown. Data for 1990 was unavailable.

care. These activities required new roles for health centers and their staffs, especially when addressing the many challenges associated with managed care – financing, legal, provider and governance issues; risk arrangements; clinical processes and outcomes; utilization management; collaborative agreements; organizational design; strategic management and planning; and quality management and improvement. Both the leadership and management expertise of health center staff has been challenged over the past decade.

Integrating Systems of Care

During the 1990s, changes in the health care industry forced health centers to examine alternative ways to remain competitive in a managed care environment. One of these ways involved becoming part of, or creating integrated service delivery networks. By collaborating with other types of providers, centers have recognized the potential to strengthen their competitive position and minimize risks, while assuring the provision of services in a broad continuum of care. Currently the BPHC encourages and supports a broad array of systems development activities and recognizes that the collaborative effort between FQHCs and other safety net providers is critical to ensuring the viability of health centers in their changing marketplace. In 1999, 51 BPHC-funded networks including nearly 250 C/MHCs are working to achieve integration of the following core functional areas: administration, clinical, financial, managed care, and management information systems.

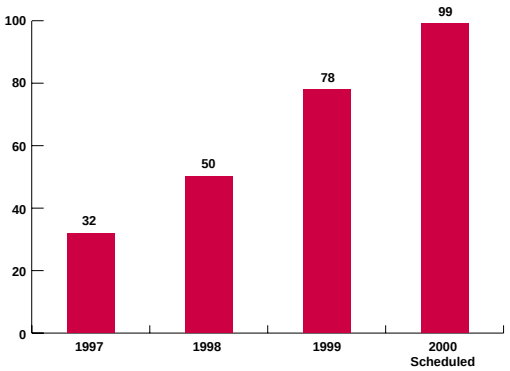
Achieving and Promoting Operational Effectiveness

One of the continuing challenges faced by health centers is access to capital necessary to renovate or build clinical facilities that enable them to remain competitive in the market. To assist more health centers undertake capital projects, a new initiative was developed that connects centers with technical assistance resources and access to capital through a Federal loan guarantee program and non-federal lenders. A collaborative effort with the National Cooperative Bank and Capital Link resulted in a coordinated process to help health centers through all the stages of capital development. Capital Link, which works in partnership with Primary Care Associations in Massachusetts, Illinois, North Carolina and Texas, has provided technical assistance to 68 health centers to date, including developmental assistance for BPHC loan guarantee applications, other loan applications, and business plan/financial analysis.

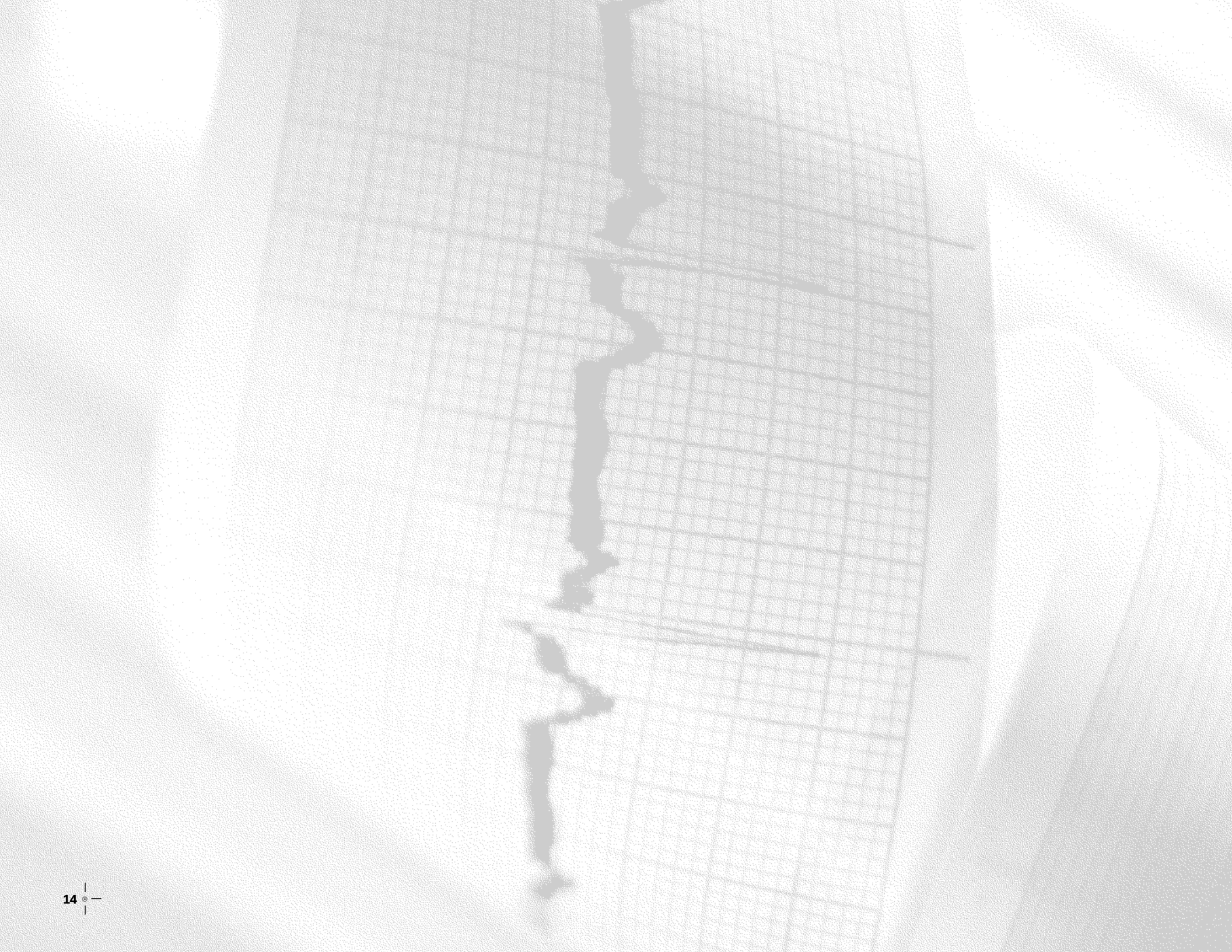
The Accreditation Initiative, a collaboration with the Joint Commission for Accreditation of Healthcare Organizations (JCAHO) began in October 1996 to promote accreditation of health centers. Following the initial pilot testing in five health centers, the Initiative was expanded to 16 health centers. As of July 2000, 175 health centers have been JCAHO accredited.

In another improvement in operational effectiveness, health centers have modernized outdated information systems. One of the key challenges faced by health centers was the potential problem associated with the changeover to the year 2000. The final year in the decade found health centers working to prevent information systems failures due to Y2K. The BPHC, working with health centers as well as information technology experts, developed resources on Y2K system remediation, a web-enabled Y2K manual to document how to fix or replace equipment, and a video tape on how to prepare for Y2K that was distributed to all BPHC grantees. In addition, DCMH made approximately $5.0 million available in Y2K funds to support 350 C/MHCs in the purchase of Y2K compliant hardware/software and technical assistance. These efforts paid off tremendously with no apparent Y2K failures reported by C/MHCs across the Nation.

Number of Surveyed C/MHCs



Approximately 25 health centers were accredited prior to the Accreditation Initiative



LOOKING AHEAD

To make comprehensive primary health care services accessible, to foster continuity of care through coordination and management, and to instill accountability in communities being served – are all original goals of the NHC program that have been realized.

These goals have been achieved largely because the services and programs health centers provide are financially and physically accessible to underserved people while being appealing and sensitive to the distinctive needs of the community.

Working in partnership, the Division of Community and Migrant Health and the Nation's Community and Migrant Health Centers are stepping into the next decade, facing many challenges in moving toward the goal of 100 percent access and zero disparities. Some of those challenges include:

Funding

It is essential that C/MHCs have a stable and increasing source of funds to serve the growing number of uninsured and underinsured people in this country. The generous increases provided by the Congress cannot make up for the costs of the increasing numbers of uninsured and the reductions possible through FQHC reimbursement changes. The need for capital improvement of facilities that are aging and in need of renovation or replacement will continue to challenge health centers throughout the next decade. Centers will need to be increasingly cognizant of new sources of funds to support infrastructure needs, and seek new and innovative ways to finance health center services and programs.

Technology

Centers will need to recognize and address the complexity of and need for information technology. The rapid changes occurring in the technology industry are having an immense effect on health centers. For example, by taking advantage of the available technological advances, health centers can enhance their ability to collect data that will help them address disparity issues as well as improve disease management and increase revenues through improved billing procedures. Centers will also need to improve efficiencies through utilizing a relative value unit based approach to tracking costs.

Effectiveness in the Marketplace

Centers must continue to improve their status as efficient health care delivery systems within their marketplaces. The reduction of health disparities will be dependent on the continuing provision of high quality, cost competitive and comprehensive care. They must address the changing demographics that are due to immigration and the aging of the people they serve. More emphasis must also be placed on Limited English Proficiency activities to ensure that the quality of care is equal and understandable for all.

Integration and Collaboration

Understanding and fostering new collaborations and partnerships with other types of health services providers and entities such as States, primary care associations and organizations, managed care organizations, hospitals, health departments as well as other local and community-based entities will become more important as C/MHCs strive to ensure access for all to primary care services. Care must be taken in the building of collaborations to ensure that the community base for the health center is maintained.

The future demands that centers strive to maintain their status as experts with experience. This is vital, especially in an environment where primary care is recognized as the appropriate setting for providing care to the underserved.

The growing number of uninsured and underinsured, the continuing impact of managed care, the increasing need to be financially savvy safety net providers, the ability to respond to a wide array of state policies – all have the potential to undermine the survivability of health centers in the years to follow. Health centers have demonstrated their capacity to adapt to their marketplace and to enhance and improve access to health care services for the Nation's underserved populations. Centers have shown that they are fulfilling the promise of thirty-five years ago.

ACKNOWLEDGEMENTS

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The Division would also like to thank the Information Dissemination & Communication Staff and the National Health Service Corps for providing photographs. Finally, the DCMH would like to recognize the skillful work of staff from Professional and Scientific Associates in publishing this report.

For additional information on this report, Community and Migrant Health Centers, the DCMH, and the Bureau of Primary Health Care, visit the website at <www.bphc.hrsa.gov>.

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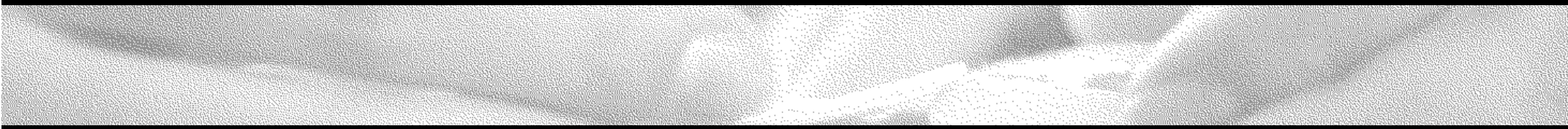

U.S. Department of Health and Human Services

HRSA BPHC Bureau of Primary Health Care

Health Resources and Services Administration